March-April, 1965

MEDICAL MISSIONARY

Themes of the Church Today
II
OPENNESS

The Church in our day has opened its windows. Light, wind, fresh vistas come through them. The open Church calls for

open eyes and hearts and minds
open hands to give and to receive
openness to every breath of the Spirit that fills the earth
openness to the world, to the present, to its real problems and values
openness to need, to the poor, the sick, the lonely
openness to all cultures, classes and faiths
openness to what is other than itself

If the world of today meets the open Church in Christians who have caught her spirit, who are full of welcome, positive, fearless, receptive, ready to change and to exchange—it will have met and recognized its Lord and found itself "at home" in His open heart.

Christ puts His finger on us, and says
'Epheta' which means be opened.

Sr. M. Lawrence, S.C.M.M.

THE MEDICAL MISSIONARY

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Cover: Holy Family Hospital in Dacca responds enthusiastically to Bengali culture. Here the Sisters and staff gather on the lawn to explore the riches of Bengali music.

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THIS ISSUE . . .

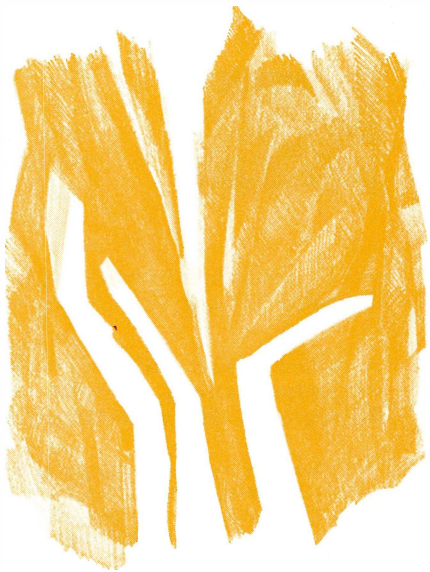
OPENNESS, our theme for March-April, acknowledges a trend prevalent in the world today, a trend which is offering opportunities for meeting and exchange, enriching and being enriched as never before. It would seem a good thing that "cultural shock" has become a major affliction in our times, jolting people to the fact of other people, other cultures, other outlooks and other values. To be aware is to be alive. To open one's self in a way that others can come in and you can go out to them is to grow and expand, broaden and deepen, to the measure of the fullness of a man.

In this issue, we have looked at *OPENNESS* from various angles and in varied surroundings. At HOLY FAMILY HOSPITAL, DACCA, EAST PAKISTAN, an earnest attempt is underway on the part of both Sisters and Bengali staff to bridge some gaps created by distance and background, through a study and mutual sharing of the rich literature, music and art of Bengal.

In another country, India, a young Sister-doctor, SISTER M. PAUL, cites specifics after her first year of medical practice: the experience of seeing disease wear a new face and of finding oneself forced to re-evaluate signs and symptoms in the light of a new milieu.

FATHER WEBER'S appreciation of the "tricks of the trade" both in handling simple tools and in dealing with fellow workers comes through in his "L & M" story. It is the honest response of one who approached a new people and surroundings with candor and sympathy.

To take people as they are and give in the measure they can receive, as illustrated in THESE ARE OUR PEOPLE: THIS IS OUR RESPONSE, is one aspect of *OPENNESS*. Sister M. Suzanna shows another side in 8 ANNAS AND 3 EGGS, the sincere appreciation of the Sisters in Thuruthipuram for a hardworking mother in the circumstances of her life. *OPENNESS* as manifested in these articles is basic in the apostolate of the MEDICAL MISSION SISTERS.



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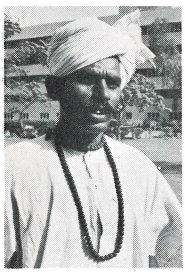


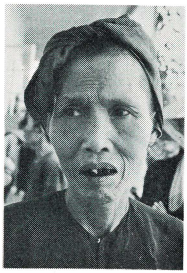
BY SISTER M. PIERRE

Care of the sick around the world is no small challenge for the Medical Mission Sisters. They must give in a way that people can receive, in a manner worthy of the Divine Physician in whose

are our people:

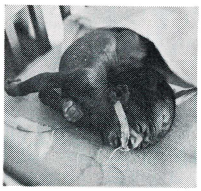
name they carry on their healing apostolate, worthy of the Church of our day. It means that they must go among Buddhists, Hindus, Muslims and animists, among Parsis and Sikhs, respecting their concept of life and its value, their outlook on disease and its cure, their taboos and restrictions. It takes them into small villages and remote bush stations, far from contact with twentieth century living, as well as into the big cities and main ports. It asks that the Sisters speak in Twi and Urdu, Bengali and Vietnamese, modern medical terms that have taken years of study and preparation to learn.

this is our RESPONSE

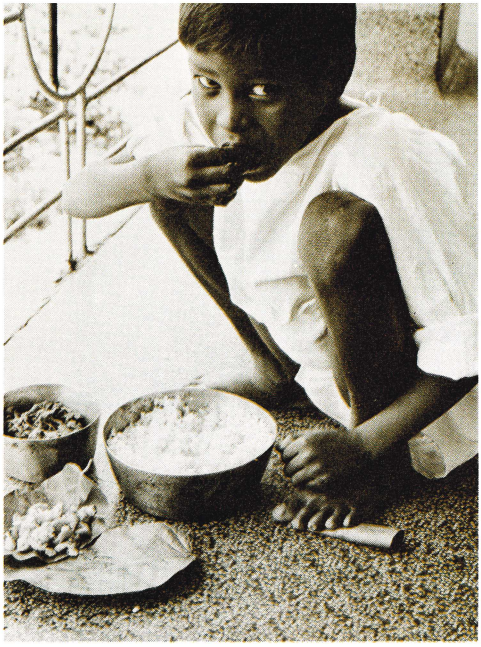


Age-old customs and beliefs have formed people so deeply that no amount of explaining, logical as it may seem to the western mind, can change them. Illiteracy and lack of sufficient food have dulled people to a point where they cannot even care for what seems so urgent and care-able to the outsider. A new nationalism has made people sensitive to an extreme degree about anything that comes from abroad and would seem to imply a lack on their part. Tribal disturbances and war with the Viet Cong have introduced another factor to weigh down lives already carrying a heavy load of disease, poverty, ignorance and malnutrition.

Yet, to all of these and in each of these environments, the sick have a right to the benefits of today's medical miracles and the Church has a duty to make tangible her healing role. Each hospital staffed by the Medical Mission Sisters has its own flavor, takes on the color and tone of the local people it serves. There is a question of giving and taking, of working within the social and economic framework of the area, of accepting limitations while continually striving to improve.

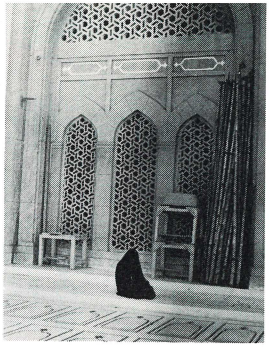


In Mandar, India, where aboriginal, tribal people may arrive at Holy Family Hospital in a basket carried across the shoulders of two men . . .



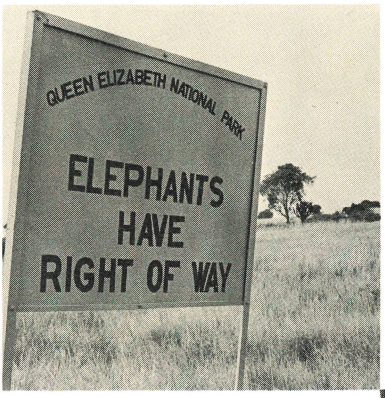
where curry and rice on a banana leaf is the daily fare . . .
where wooden plow blades and drums for dancing are
in demand each market day . . .

where the Sisters must be concerned not only about the
latest cholera or typhoid fever epidemic but also, how
best to train the local girls who come to the Mandar hospital
in greater numbers than to any other Catholic school
of nursing in the country . . .

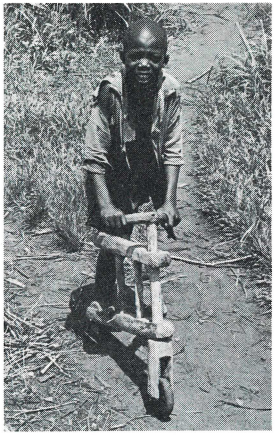


or in Karachi, main port of West Pakistan, where Holy Family Hospital's doors are open to people of many races and creeds . . . where a single, veiled woman must remain outside the mosque to pray but may enter freely a hospital staffed by women doctors and nurses . . .

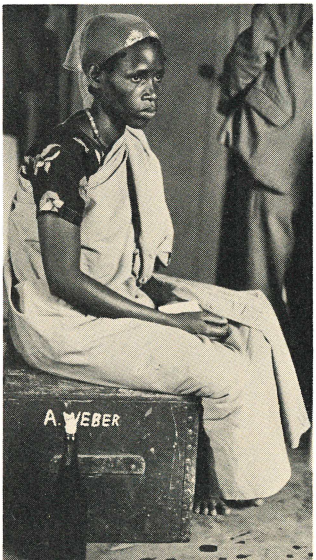
where a newborn baby is admired by both mother and Sister and introduced to the world of sound with verses from the sacred Koran chanted in his ears . . . where a Sister once more becomes a child to learn a language well . . . where lamps are lit for others and careers of service are begun . . .



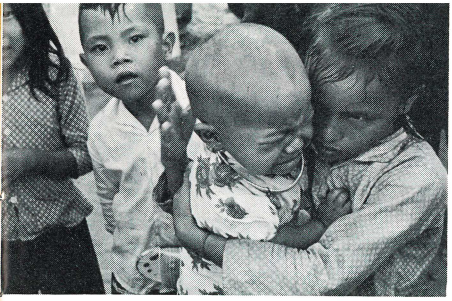
or in Uganda, in East Africa, where elephants have the right of way and patients come out of the bush at the sound of the drums announcing the arrival of the Sisters' mobile clinic . . . where a modern supermarket looks pale compared to the hues and sounds of the open-air kind . . . where bicycles for fun are homemade but those for visiting the sick are of a sturdier kind . . .

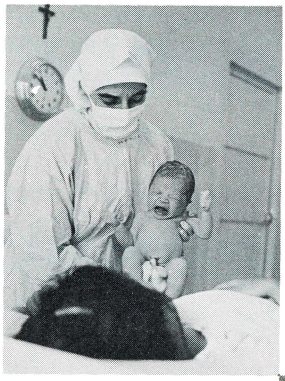


where disease has no respect for age and sorrow molds a face . . . where students from many tribes come together over a common problem and men from warring tribes discover that a Christian hospital has no other message than one of love and service . . .



or in Vietnam, where patients, more than can be treated in a morning, crowd the out-patient department at Holy Family Hospital, where white mourning bands speak of a hidden sorrow and children have fear and mistrust in their eyes . . . where people are physically sick and sick unto death of war and night raids . . .





where in spite of all, new life brings joy and hope for yet a better day . . . and planting for another season goes on . . . as does care for the sick, young and old . . .

in these and many other areas of the world our people live and we are there among them.

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BY SISTER M. ANGELA

After the hustle and bustle of departing for Dacca, East Bengal, Pakistan, after the crowds and the rush of a large international airport, the stillness of the East comes as a marked contrast. However, to one who is sensitive to her surroundings, the silence soon speaks. In fact, it sings, for the new arrival quickly discovers that the Bengalis have a song for everything.

Every Bengali enjoys the sense of being a singer. The sellers on the railway platform offer their goods with a refrain; the beggar opens your purse with a touching melody; the boatman along the river suddenly bursts into song. Even the young boys who pound bricks into dust, work to the tune of a two-stringed violin. The peasant guiding his plough, the hiker along his dusty path, the craftsman at his work, each has a song to sing.

There is a folksong for every occasion, suited to every mood. These songs are divided according to subject matter. A most important group is the *bhatiali*. *Bhat* means "ebbtide." These songs are sung by all the boatmen as the boat sails downstream or by laborers in the field when they relax after a hard day's work.

The *sari-goan* are songs of vigor sung when the boat is struggling upstream and in days of monsoon when the rivers are flooded and the current strong. The regular and powerful rhythm is accelerated, faster and faster, in a race. These songs reflect the Pakistani's closeness to nature. The vast majority of the people till the land and their business is to learn to live according to nature's whims. Torrential rains beat down six months of the year. The mighty rivers—the Ganges, the Brahmaputra and the Meghna — stretch their innumerable tributaries in a vast network over the country. Men of a different environment would react otherwise to such situations. But here in Bengal, intense feelings find a more complete expression in art and in music. The unusual powers of expression that these people possess have formed a rich heritage of folksong and dance.

The *kirtan* is a special night-long session of devotional songs, an expression of the common

a burst of Song

man's aspiration toward the ideal Being. Many of them are influenced by Sufism or ancient mystic Muslim poets. Thousands of village people attend the big Hindu and Muslim festivals for these singing concerts.

The Passion has been translated into Bengali verse and is sung and dramatized as a *kirtan*. The men at our hospital have a Drama Club which presented one of these *kirtans* several years ago. It lasted far into the night. The fervor and intensity of feeling among the men was a moving experience to see.

Holy Family Hospital has responded more enthusiastically to Bengali music than perhaps to any other of its cultural expressions. Many avenues have led us to this. After perceiving the importance that music plays in the lives of the people, after hearing it all around us, the Sisters began investigating and trying to learn more on their own. Sister M. Rachel was particularly interested in the tablas, two small instruments built somewhat on the principle of drums. One, the *dohika,* is played with the right hand and is tuned at will according to the pitch of the voice. It gives a great variety of sounds. The *boyan,* played with the left hand, is fixed and makes only one sound. The tablas are extremely important in Indian music. They give the beat and set the rhythm

Classical dancing, a language in the fingertips.

for any piece of music.

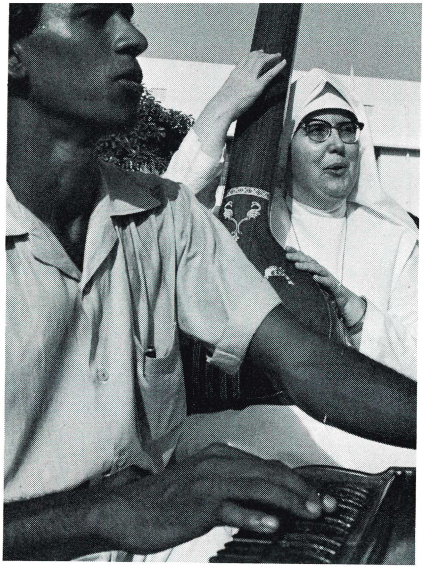
It was a happy coincidence that Bert Gomes, who was trying to earn enough money to go on with his musical studies in Lahore, came to Holy Family and accepted a job as cleaning supervisor. Sister M. Rachel was head of the housekeeping department. After the day's cleaning was finished, she was able to take tabla lessons from Bert and learn much about the fundamentals of Indian music —which is the music of Bengal. Happily enough, Bert found a very good master to teach him right here in Dacca. He says this is an ideal life, "to be of service to my people by working at the hospital during the day and to be able to study the music I love in the evening." He has composed many songs, one of them our very lively Nursing School song. The climax of our musical exchanges came at the close of Holy Family Day celebrations last year. After the games and races and bingo were finished, we all sat down together under the trees and had a real Bengali "jam session" with everyone contributing something.

Indian music is ancient and intricate. In their system, melody *(raga)* and time measure *(tala)* are the basic elements of the composition. The European system has added harmony, using the two basic modes, major and minor. Indian music employs three or four kinds of time measure within one piece. In addition, the piece may modulate from one scale to another, adding four, five or six flats to express a sorrowful mood.

In the formation of the *ragas,* all possible combinations of notes are used for creating emotional and aesthetical effects. Each *raga* flows in a melody type or mold. There are 36 original and 36 derivative *ragas* and as many as 1,000 subdivisions. There are *ragas* which arouse devotional fervor or excite compassion or love; there are melodies with a great degree of pathos, tenderness, appeal or devotion. *Mamavathakrina* is a *raga* which expresses the deepest affliction of the soul.

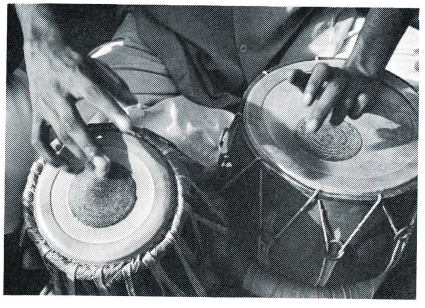
In order to be an accomplished musician according to this system, a large degree of discipline and imagination is required. The artist must create his song within the confines of the precise notes of the chosen *raga.* The great artists improvise: the tabla beat sets the pace and rhythm while the vocalist or sitarist weaves many patterns of melody and strives to give the mood of the *raga* to his hearers. It is not uncommon for an inspired performer to sing and play for hours or all night long.

Actually Indian music is similar to Gregorian chant, which is of much later origin. Although the origins of Gregorian chant are uncertain, it may very well have been influenced by the Oriental system. The modes of the chant correspond somewhat to the *ragas.* Perhaps that is why the Gregorian has such an appeal for Bengalis. They learn it by heart very easily and here in East Pakistan some of the parish congregations have



Talented Bert Gomes shows his skill at the harmonium while Sister M. Angela, the author, tries her hand at the tambura.

Sisters and staff make up the Holy Family Hospital ensemble.



The tablas are rhythmic essentials for any piece of Indian music.

sung the Common of the Mass with fervor for many years.

The Oriental Institute of Music established in Barisal, East Pakistan, in 1959, offers courses in sacred music written in Hindustani notation. One of the Sisters took the course, and we at the hospital were then launched into the stream of Indian sacred music by Shushil Baroi, a Bengali composer who came to instruct us. The whole compound—men, women, Sisters and students—gathered to learn his newly composed mass. On the feast of Saint Joseph the Worker, we had our first joyous celebration.

Sooner or later we all realize that the best way to come close to a Bengali person is not merely to speak his language but to communicate with him on a deeper level by penetrating the rich store of his literature. To do this a good command of the language is, of course, fundamental—something that takes months and even years to acquire. Once one enters into Bengali literature, a whole new approach to life opens up. Perhaps the best way to learn how a people will react to situations is to read their literature. Even an English translation of Bengali short stories is fascinating from this standpoint. There are a number of expressions which can never be rendered exactly into English. A whole textbook on psychology could be written on why a Bengali would say *"bhalo lage na"* ("it would not be good" is as close as you can get) instead of a direct "no."

One of the world's incomparable poets and a man who blends the soul of the peasant's folksong into the classical music and poetry

of Bengal is Rabindranath Tagore, a penetrating searcher of hearts, a lover of nature, and a deep lover of God. He translated his own poetry into English and won the Nobel Prize for literature in 1913. These translations capture the brilliant imagery but cannot capture the subtleties of rhythm and metrical devices of his poems, which, incidentally, he also set to music. An introduction to his poetry in English only awakens a great thirst to be able to read and comprehend the original.

We recently spent a most delightful afternoon at the home of a brilliant Muslim lawyer, a close friend of ours. He played his collection of Tagore songs, pointing out his favorite:

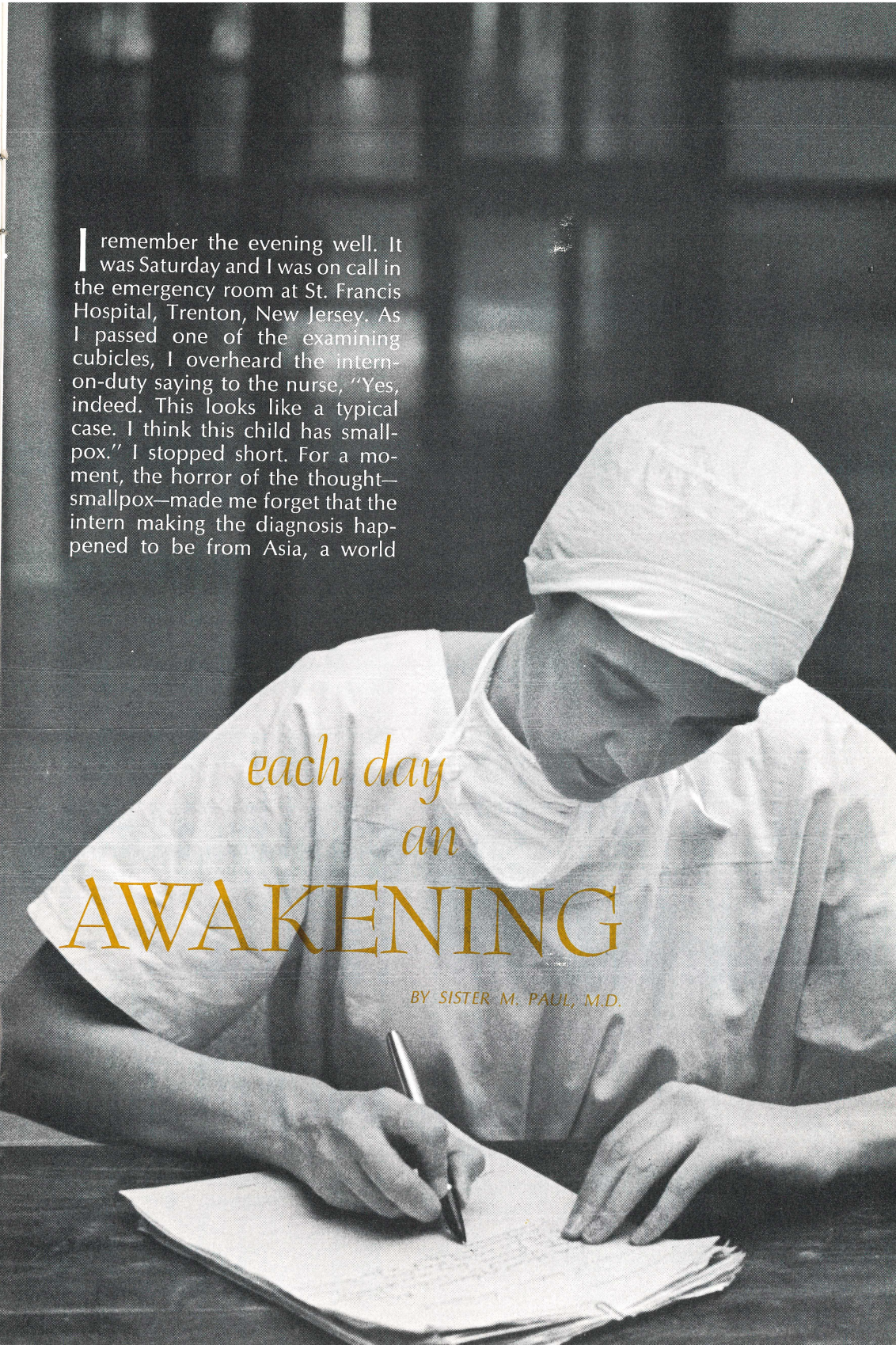
> When the heart is hard and parched up, come upon me with a shower of mercy.
> When grace is lost from life,
> COME WITH A BURST OF SONG.
> When tumultuous work raises its din on all sides, shutting me out from beyond, come to me, my Lord of silence, with Thy peace and rest.
> When my beggarly heart sits crouched, shut up in a corner, break open the door, my King, and come with the ceremony of a king.
> When desire blinds the mind with delusion and dust,
> O thou holy one, thou wakeful,
> Come with thy light and thy thunder.

I could not help but reflect on the ecumenical meaning of this meeting. Tagore, a Hindu poet with a rare gift of experience with the Divine, drew together a group of Sisters and a Muslim family. In this empathy with the deepest aspirations of men, we can come closer to God and to each other.

In addition to its literature, its instrumental and vocal music, this subcontinent also has a rich heritage of dances, ranging from religious and traditional temple dances *(Bharata Natyam)* and dance dramas *(Kathakali)* down to simple folk dances. The gesture language of the fingers follows rules that are as strict as they are subtle, having more than 200 gestures to symbolize words. The dance also has various facial expressions and movements of the eyes. These combined with rhythmic movements of the feet and body narrate a story, a means of expression as eloquent as the spoken word. With their infinite variety of combinations they are used to interpret dramatic works —poetry, prose and songs.

The parables and gospel stories seem made for this type of presentation. The Annunciation, the many miracles performed by Christ, the story of Mary Magdalene, are especially fitting.

The result of Holy Family Hospital's response to Bengal's culture has been a perceptible communion of spirit between the Sisters and the staff. This in turn reaches out to embrace the patients. We have come to realize a little more about the rhythm of life. This rhythm is reciprocal and we know that we are called upon not only to give and to serve but also to receive.



each day an AWAKENING

BY SISTER M. PAUL, M.D.

I remember the evening well. It was Saturday and I was on call in the emergency room at St. Francis Hospital, Trenton, New Jersey. As I passed one of the examining cubicles, I overheard the intern-on-duty saying to the nurse, "Yes, indeed. This looks like a typical case. I think this child has smallpox." I stopped short. For a moment, the horror of the thought—smallpox—made me forget that the intern making the diagnosis happened to be from Asia, a world

where smallpox is endemic. I quickly called him into the back room.

"It is not exactly my business, Doctor, but your diagnosis of smallpox could put us in the headlines across the country by tomorrow morning." "How's that?" he asked. "Well, you know, smallpox is rarely seen in this part of the world. One case, and we'd be famous." He smiled rather sheepishly and then turned back toward the examining room for a second look at his patient. Needless to say, we were not in the headlines the following morning!

In the past year, here at Holy Family Hospital, Patna, India, I have found myself in the same sort of situation as that intern in New Jersey. True, I have been prepared in many ways for my missionary life but a new environment has presented a whole list of diseases which for me are as new as they were commonplace for my intern friend in the emergency room. Just as he had to get used to thinking along new lines in his differential diagnosis, I, too, have had to do the same.

One of my teachers in medical school used to repeat almost every day to eager medical students who were trying to find a place for rare syndromes, "Remember, gentlemen . . . and ladies . . . common things are common!" I would now add, "What is common in one place might be, and often is, a rare finding in another surrounding." The fine print at the bottom of the page in our medical textbooks back home has become the daily routine here in India.

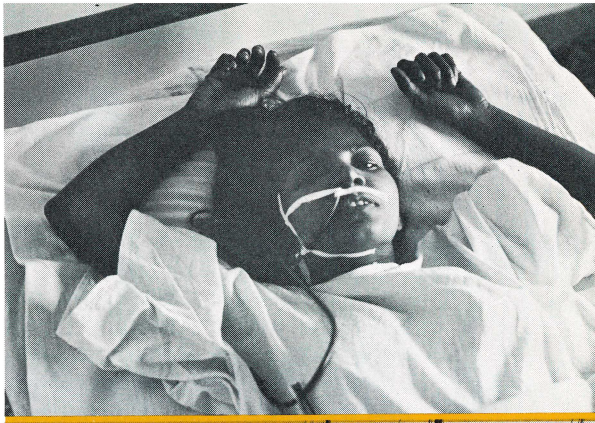
My new world, Holy Family Hospital, Patna, is situated right across the road from the River so sacred to the Hindus, the River Ganges. To walk along its banks, watching the fishermen wash, knot and mend their nets, is to find oneself back in the time of the Apostles and their wooden boats. Little has changed in the last centuries. For Hindus, who last year made up 85% of our patients, Mother Ganges is so beneficent that they will never hesitate to bathe in or drink of its healing waters. I had a good and vivid example last week. A post-operative patient on discharge walked directly down to take a bath in the River, and returned a few days later with a terrible infection.

I was introduced gradually into this medical world by Sister M. Frederic, a Sister-doctor who has been ten years in India, and with whom I have worked hand-in-hand for many months. It was she who taught me to have a "suspicious mind" about tuberculosis, hookworm, a history of malaria, etc., when examining a patient for the first time. Under her supervision and guidance, I have spent full and rich hours in the Out-Patient department, operating room and on the wards.

Other facts about India, ones I learned in our Oriental Civilizations class back home are now being woven into the warp and woof of everyday life. I once studied that a large segment of the Indian population is not yet

aware of the importance of the most basic sanitary requirements. Each day I see evidence of this. Or, again, I studied that age-old eating habits are so deeply ingrained in the devout Hindu that he would die rather than violate them. Right now, here in Bihar, one of the poorest States in the country, there is a scarcity of food. Still, many people will eat nothing if it departs from their dietary restrictions. The reasons behind all this are not so obvious at first, but there is much to be learned living side-by-side with a people. This first year of my Indian medical practice has passed. Each day has been a new learning experience, each day an awakening to new disease entities. Let me cite a few examples for you.

One day after I had been almost a year in Patna, a technician from the laboratory interrupted afternoon rounds by handing me a hemoglobin report on a newly-admitted patient. "Hmm, I see, 2.4 grams." History and physical: Female patient, 24 years old, complaining of weakness. Two previous pregnancies, last child 3 years old. Pulse 88, volume good. Blood pressure is good, 110/60. Stool test shows hookworm. "All



A tetanus patient at Holy Family Hospital, Patna, one of the many diseases Sister M. Paul has to encounter each day.

Sister M. Paul and Sister M. Frederic walk along the sacred Ganges, whose waters are a source of the dreaded cholera.

Making ward rounds yields many new discoveries to newcomer Sister M. Paul, M.D. (left), familiar tales to veteran Sister M. Frederic, M.D.

It's a matter of life and death in the operating room at Holy Family Hospital, Patna.

right, let us treat the hookworm and give her iron therapy. If her people agree to a blood transfusion, it will hurry her recovery." We went on to the next patient. Suddenly it struck me that a little more than a year ago, my reaction to such findings would have been so different. At Trenton, we were alarmed when a report of 8 grams came in. But now, here in Patna, it has become a daily finding. Severe anemia secondary to hookworm or to poor nutrition is very common in both male and female patients. Interestingly enough, in none of my medical textbooks have I been able to find a statement regarding the treatment of *severe* anemia of pregnancy, or at least we do not seem to agree on the meaning of the term "severe." I mean 1.6, 2.3 and 3.4 grams of hemoglobin as we see it around here!

Almost every medical student in the United States could find something to say about cholera, even if it might only be the following: "It is endemic in Asia, especially on the delta of the Ganges River, which is the important persisting focus." Here, we are practically on top of the Ganges and, indeed, *see* cholera with its devastating dehydration. It is such a known scourge that even the less educated people who bring in a pulseless, cold and clammy patient, answer the question, "What happened to him?" with an immediate diagnosis—"Cholera." Then they add, "He has not voided," with a terrified look on their face. They have learned through experience that this is the most dangerous complication of the severe and quick dehydration process which takes place in a few hours.

This year, we had at least six severe cholera cases, with almost complete anuria and all the accompanying findings of uremia. Here, again, I am referring to true severity, three patients who for two days had an output of 10 to 25 cc. of urine (normal output: 800-1600 cc. per day). I was happy to see that we could, with good nursing care and with careful control of fluids, intake and output, save more than 50% of those who arrived in the worst possible condition.

Last night I was called to the emergency room by a doctor who is from Germany and is presently working on our staff. He felt a little puzzled by the case at hand. The patient was 24 years old, with a vague story of having been treated by the village doctor for a fever of two weeks duration. He had been semi-conscious for four days. On examination, the patient looked thin and emaciated, no recordable blood pressure or pulse. According to the family, he had never been sick before. The patient was afebrile. Neck was supple. No localizing neurological signs. Doctor had already done a spinal tap and it was negative. The blood count and urinalysis report had not come back as yet. My suggestion was to order a blood sugar and blood urea. "Useless, doctor," he said to me. "How can

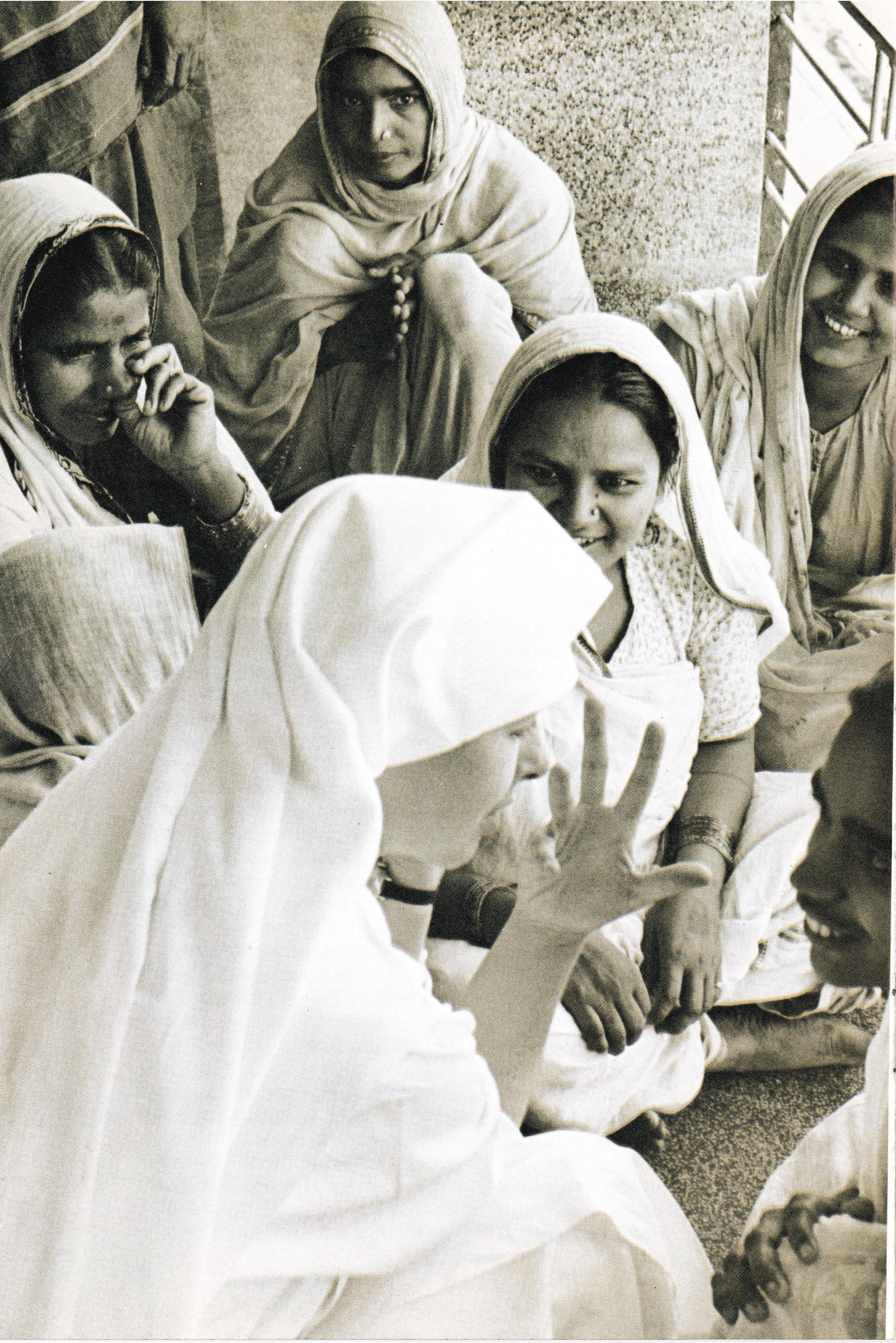
this be a diabetic coma? No acetone smell, the skin is not warm. Have you ever heard of diabetic coma without these findings?"

"I realize, doctor," I replied, "the case is not typical, and we have no history, but I am more and more convinced that we must write a few footnotes to the books we studied in medical school for the use of future medical missionaries. The title would be something like: 'Where Common Findings are Atypical.' If, for example, we were waiting to find the *typical* textbook picture in order to diagnose ectopic pregnancy out here, we would miss the diagnosis in probably 90% of our cases. They do not come in with a classical history of sudden abdominal pain and in shock, even when the pelvis is full of blood. At any rate, doctor, I think it would be a good idea to order a blood sugar test." He did as I suggested. The report came back, 576 mg., and even I was surprised at that! (Normal: 80-120 mg.)

I could go on . . . the case of a little nine year old boy with a history of a circumcision done outside, and now in the emergency room, with high fever and difficulty in voiding. After examining the boy, we found clinically all the signs of a generalized peritonitis. It was impossible to get the relatives to give pertinent information that would help in the diagnosis. They kept on insisting that there was only one problem and it all started with the circumcision. Another doctor and myself came to the same conclusion—to forget the circumcision and proceed with what we find. Peritonitis —etiology unknown—possibly a perforated appendix, based on the laws of probability. We proceeded to hydrate the child, gave high dosages of antibiotics, and finally did a laparatomy. It was, indeed, a generalized peritonitis but the cause was a surprise to us all. A psoas abscess, level of Dorsal 12 and Lumbar 1-2, had perforated the posterior abdominal wall. We put in a drainage tube, started antitubercular treatment and the child recovered. No one had ever told me that such things as that could happen!

These are just a few samples to illustrate the type of medical problems a new milieu may present to a newcomer. Just as much as the scenery is different, so are the people and their needs, their diseases and their response to treatment. Our patients are *so sick* when they come that one often feels quite discouraged and is tempted to say, "What is the use of starting treatment? He is moribund." Still, in this past year, I have seen the "almost dead" come to life and have grasped more deeply the old saying, "where there is life, there is hope."

It is my privilege—and I feel this sincerely—to be able to work here in India. Our patients are giving us much more than we are giving them—the unique opportunity of taking care of some of the most deprived of Christ's suffering members.



OPENNESS
of Missionary Sisters

There is no part of a missionary
that can be closed
cut off from the people she has come to serve.
She is one who belongs wholly to others.
Her people know they can come to her
because she first came to them.
She came with reverence for each man
respect for his manner
with eagerness to enter in and discover
to love and to serve:
these are her credentials.
She came not only to give
but to receive
a new culture
a whole new way of life.
This opening to a love of new values
makes a missionary approachable on all sides
at all hours
to all men.
It makes her totally available for service.

for further information on the vocation of the Medical Mission Sisters, write:

MEDICAL MISSION SISTERS
PHILA. 11, PA.

8 annas and 3 eggs

BY SISTER M. SUZANNA

When you are a little girl pinched up by anemia and malnutrition, you really don't care very much whether you live or die.

"How did you ever manage to run a hospital in a place like that?" People ask the question so often after listening to stories about our hospital in Thuruthipuram, South India, that I've come to expect it now. Sometimes, I look back and wonder myself . . . how did we do it? So many days when there wasn't enough staff, enough water, never enough money . . . not enough of anything but work and lines of sick people needing help. I wonder, sometimes; but deep down I know the answer. It was given some 2000 years ago in just eight words: "Give and it shall be given to you."

Mary is just one but her story belongs to many, to the majority, I would say, of those who live in Thuruthipuram and try to eke out a living under its tall, swaying coconut palms. She was admitted for anemia and malnutrition, a pinched-up little mite, too listless to care whether she lived or died. Hookworm treatment, liver and iron therapy, a couple of blood transfusions, plus three good meals a day and it wasn't long before our mite blossomed into a perky little lady. As soon as she felt better, she wanted to help—as only a six year old can—giving the younger children in the ward their milk and telling them that the wheat cereal served between meals wasn't half bad. She even put on a fairly convincing demonstration for their benefit.

Mary's mother who came daily to see her was delighted with the change in her daughter and often tried to say thank you. Her smile

Beating coconut husks from morning till night demands long tiring labor and pays barely enough to survive.

—all she had to give—did the trick, growing broader and broader as Mary grew fatter and fatter. But on discharge day, a month later, the picture changed, the smile faded, a cloud appeared on the horizon . . . the bill.

Item by item, it looked like this. 30 days of hospitalization . . . no charge. The ward beds, doctor's daily visits, nursing care, etc., are all free in the Thuruthipuram hospital. Food . . . well , it was easy enough to manage food from the hospital kitchen for one little girl without it appearing on the bill, so there was no charge on that account. Medicines and injections . . . Mary had hit the jackpot, as shortly after she was admitted a whole shipment of donated medicines came our way making it possible to give her iron and vitamin tonics, B_{12} and liver injections, again without any charge. One of the priests who had heard about Mary donated blood for two transfusions, so that also could be marked off. Still, with every sort of concession, a few items just couldn't

It's never easy to say "goodbye," and so much harder when your new friend has made the sickness go away, has even made you feel like singing and laughing and dancing again.

slide in under the "free care" heading. When totaled, the full bill for one month amounted to 23 rupees (about $5.00), ridiculously low even by Indian standards.

But Mary's mother, a widow, supports herself and four children by beating coconut husks to make coir literally, from morning to night. Working hard, on a good day, she can earn 8 or 12 annas (about 15¢). To her, a bill of 23 rupees looked far from "ridiculously low."

She came to me with both hands full, the bill in one and 8 annas and 3 eggs in the other. She begged me to please go with her to the "Mother Superior" to tell her that she really appreciated all we had done for Mary, that she would always be grateful to us, but . . . 8 annas and 3 eggs was all she could possibly scrape together toward the bill.

When I looked at the 8 annas, precious pay for a full day's work, I had the sinking sensation that this meant she and the other three children had not eaten anything since the previous day. The 3 eggs, she explained, were all fresh, one laid by her own hen and the other two begged from neighbors whom she would pay back when her solitary hen produced two more.

Together we went to the office to discuss the matter with Sister Rose Clare. As we walked along, I couldn't help but remember that our own payroll was due in just three days and I knew we didn't have sufficient money to meet it. However, before Mary's mother and I were halfway through our tale, Sister Rose Clare interrupted with, "Well, if this is all she can give, that's all I can ask." Then she added, "and in view of the fact that we've just spent a month treating this child for malnutrition, she'd better keep the eggs too."

It was close to 11:00 A.M. when Mary made her rounds to say good-bye to all her friends, packed up her little cloth with comb, hair oil and glass, and said a final "thank you" to me. An hour later, the noon mail arrived with a letter for me. A teenager from my hometown had promised to send a donation from his first paycheck if he would get a job for the summer. The money was earmarked "to be used for the care of a poor child in your hospital." The amount —$5.00. Coincidence? Perhaps. I have always been convinced that Providence is the better word.

YOUR WILL

Your will can help the Medical Mission Sisters bring Christlike charity through their medical work to areas of greatest need around the world. The following approved form of bequest may be used:

"I hereby give (devise) and bequeath to the Society of Catholic Medical Missionaries (also known as the Medical Mission Sisters), an institution incorporated under the laws of the State of Maryland, and its successors forever the sum of $_____ for its purposes."

If you have already made your will, it is not necessary to make a new one. It is sufficient that a codicil be added, using the above.

thanks to L&M

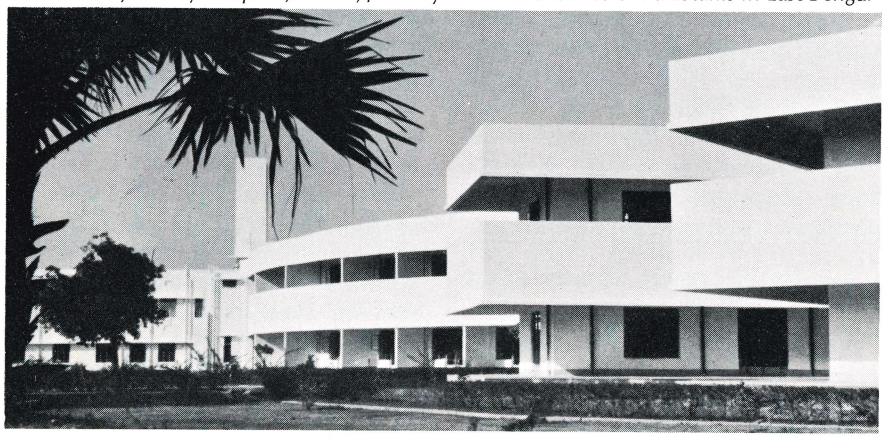
BY REV. ANTHONY WEBER, C.S.C.

Starting a hospital from scratch isn't easy, Mother M. Benedict, M.D., will tell you. Directing hod-carriers with their pans of cement is an important part of the job.

L is for Lawrence Gomes. M is for Modesti Musoka. Lawrence is a Bengali; Modesti, a Mutoro. I met Lawrence years ago, and Modesti is now my right hand man here in Fort Portal, Uganda.

Back in 1952, on a ten-acre plot outside Dacca, East Pakistan, Lawrence directed laborers in rigging up a GI war surplus tent which served as temporary housing quarters until another building could be completed. The heavy monsoon rains had abated. Squatters had been cleared off the land and Lawrence directed the felling of a huge mango tree, much to the chagrin and threats of local idolaters. He held out a medal of St. Joseph for a blessing and, while he and his crew—carpenters,

Holy Family Hospital, Dacca, proudly serves thousands of Pakistanis in East Bengal



Rev. Anthony Weber, C.S.C., finds himself at the bottom of another mission project, renovation work at Holy Family Hospital, Fort Portal, Uganda. Sister M. Gregory, M.D., inspects the latest addition.

plumbers, mechanics, masons and hod-carriers—stood by, we "buried" St. Joseph to start foundations for the Medical Mission Sisters' Holy Family Hospital in Dacca.

Lawrence was a big, husky fellow, very neat and reliable. In the evenings before he allowed his exhausted crew to retire, he paraded them up and down, saying the rosary. No one could accuse us of not seeking God's help on this venture, and what was equally important, asking for rupees! (Pakistani currency). These had to be begged, borrowed, or purloined by Sister M. Benedict. Today, her monument stands tall, proudly serving thousands of Pakistanis in East Bengal.

During the building of Holy Family Hospital, Dacca, Lawrence was all over the place, supervising, scrutinizing, poking here and there and innovating. When the second storey was going up, I became very intrigued at the manner in which the builders transported their materials up to the top. Bamboo poles were stuck in the mud, latched together with jute rope, criss-crossed and spliced. Then hod-carriers proceeded to climb up and down on this flimsiest of scaffoldings I've ever seen. "Don't worry, Father," Lawrence advised. "This is the way we do it over here. Bamboos are cheap and plentiful. Jute is grown in our own back yard, and the porters are lissome, long-toed and climb like monkeys." I agreed, but I never personally developed too much grace or agility in escalading this rigging.

After a roof slab was poured and allowed to harden, another unique operation was performed in order to make it waterproof. Lawrence directed a strange group of people, old widows and bedraggled kids, to a section on the second floor. All at once, a slouchy fellow with an umbrella and violin took over. "What's the idea, Lawrence?" I bellowed. "Is this a traveling circus?" Lawrence quickly intervened and explained what they were going to do. I soon had to agree that they were excellent waterproofers. The recipe? Simply spread a five inch layer of moistened brick dust *(surki)* and lime over the roof slab, allow the maestro, umbrella over his head and violin ready for action, to start the orchestration, and presto! The surface is soon rainproofed as the squatters, with wooden slats, pummel and beat the mixture until the surface is smooth and annealed. You've never heard such pandemonium. In the process, neighbors

Rev. Anthony Weber, a veteran Holy Cross missionary, has spent many years in East Pakistan and, more recently, in Uganda. In both areas, Medical Mission Sisters have been the recipients of his many services and kindnesses.

have to be very patient and resigned to forfeiting a few siestas, while "McNamara and his Staccato Band" perform on a roof top to make their meager living.

As you observe native talents and become interested in peculiar methods of doing things in a foreign country, the impression sticks and you like to describe them. Carpenters in Bengal, for instance, usually squat on the ground while sawing or ripping a plank. The rough board is propped up against one knee and held firmly, as in a vise, between the toes. The carpenter in Uganda, however, does it differently. He usually uses a bench with a homemade vise and cuts away from himself, unlike the method used by Europeans.

Lacking mechanical devices to hoist materials onto tall buildings, the Bengali, for one, "uses his head." He fills a panful of concrete, adjusts it on a turbaned head, climbs up a rickety scaffolding as he holds on with one hand and balances his bucket with the other, until he reaches the top, where he dumps the mixture on the planking and iron network. Masons level it off and a roof is made.

To try to finish a prepared area of 50' x 50' before nightfall, there is a procession of these hod-carriers, climbing up and slithering down like a slippery bucket-brigade. At the bottom of the scaffolding, Lawrence was usually seen passing out a smoke *(biri)* to each carrier, who then hurried away for another load and another *biri*. The quicker they loaded up, the more *biris* they received—enough for a week's supply and a welcomed *bakseesh* (tip).

In East Africa, progress in skills and craftsmanship began within the last sixty years when Stanley and Livingston blessed the horizon. In their day, they saw only grass huts—"mud and wattle" dwellings—few roads and primitive skills in making bows and arrows, spears, drums and pottery. Today you ride on excellent highways (if you own a car) and can reside in beautiful cities. In the bush, people also enjoy better living conditions and are increasingly helped by the African boy who has graduated from a mission technical school and returned home with his handmade box of tools to start a shop in his native village.

I first met Modesti three years ago. As he walked toward me with his bag of homemade tools strung over his shoulder, I saluted him and said: "Hello! How are you?" He replied in perfect English. So began another friendship and cooperation in doing work in the missions, work for the same Medical Mission Sisters who had settled this time in Fort Portal. Like Lawrence, Modesti is very reliable, skilled and faithful. However, because of his first name, I know he wishes to remain modest, so I won't praise him too much. Besides, he is on my payroll!

To you folks back home, L and M may mean "Less tar, more taste." To me, it means Lawrence and Modesti, two wonderful helpers —two worlds apart.

NOTES from our houses

PHILIPPINES

Bless This House

January 17th marked the solemn blessing of our new novitiate and the completion of four years of pioneer work here in the Philippines. Mother Anna Dengel was present for the occasion. 400 guests filled the spacious front lobby as the Most Reverend Alejandro Olalia, Bishop of Lipa, gave the opening address. Mr. Manuel Cuenco, Secretary of Health, and Doctor A. M. Malik, Ambassador of Pakistan, were the guest speakers. The new building stands three stories high and is surrounded by twelve acres of land with many newly planted coconut trees. The building itself is far from finished. We hope with the help of our many friends to be able to fill in the spaces. We are most grateful for their financial assistance, their advice and encouragement, their moral support and prayers. Please keep them coming.

Philippines Novitiate
Lipa City

GHANA

Language With A Beat

Drums are indispensable to the life of the African. They are used for communication during certain tribal rituals; they beat out news, they call people together, they uphold the dignity of the royalty and they are certainly a means of entertainment. In sorrow and in joy, in peace and war, in trifling matters and events of great significance, always the beat, beat, beat of the drums fills the air. The rhythm cannot be matched anywhere. To play the famous talking drums takes great talent. It is an art in itself which is passed on from father to son. One of the

drums is a male and the other is called the female drum. The female drum is a bit smaller, and in every message, a real dialogue goes on between the two. In many of the messages I have heard, it seems that the female drum has always had the last word. Only last week, I could pick out that distinctive beat that is always used to call the people to the chief's house. Sure enough, it was the female drum who beat brc brc brc, come, come, come, at the end of the message.

Sister M. Laboure
Holy Family Hospital, Berekum

INDIA

Now I Have Seen

I had the privilege of attending Mass at the Cathedral the evening our Holy Father came into Bombay. Sisters from all communities had gathered to welcome him. His Holiness gave a very short talk on the fact that religious must persevere in their vocation as they are cherished daughters of the Church. Somehow or other an old wrinkled malayale lady managed to get into the Cathedral and as far as I could see she was the only lay person there. She had gold earrings from top to bottom of her ears and tears were streaming down her face as she looked at the Holy Father. She kept repeating in malayalam: "Now I have seen the Pope—now I have seen the Pope." Her feelings represented those of all the people—religious and lay—who had flocked to Bombay for the Eucharistic Congress.

Sister M. Caroline
Holy Family Hospital, Bombay

UGANDA

Delivery Service

We first met Perusi in May of 1963 when Sister Gregory did a Caesarian section on her for obstructed labor. She had a very stormy course and we expected to lose her several times. After almost two months in the hospital, she finally went home to Bwamba. About a month ago she showed up at the Kigarama dispensary 8 months pregnant, and Sister Gregory recognized her. Kigarama is only six miles from Fort Portal. Sister explained how important it was for her to come into the hospital for delivery, as upon examination it was obvious that she would have obstructed labor. Two days before Sister Gregory went on holiday, Perusi still hadn't come to the hospital. Sister knew she was due to come at this time so we decided to try and locate her, knowing she must be somewhere in the vicinity of Kigarama. Two

miles in from the road we found a very nice plantation. Perusi lived there. Her husband, a trader, was in Bwamba at the time and we had no idea how she would react to our suggestion that she come into the hopsital without his permission. She consented and in no time at all was quite dressed up for the trip. Sister performed a Caesarian section, delivering a lovely baby boy. The husband returned from Bwamba the evening before Sister left on holiday and was as pleased as punch with his new son. When he heard Sister would be leaving the next day, he went back home and returned with a cock for her as a sign of his gratitude.

Sister M. deMontfort
Holy Family Hospital, Fort Portal

KENYA

Floored!

The day we installed tot-size beds in the children's ward was labeled a BIG day and we thought our problems were automatically solved. All along we had been forced to tuck the little ones into adult beds and held our breath for fear they just might tumble out. Shortly after the beds were installed, the mothers began to come, one by one, asking to take their children home. Word spread quickly, and several mothers who had come to the Out Patient Department with very sick children were reluctant to have them admitted to the hospital. What could have happened, we wondered, both to ourselves and out loud. Why, only a short time before, the ward was filled with all sorts and sizes of children, and a corresponding number of mothers. It is expected that when young children are admitted, the mother comes to stay with her child. Both mother and baby are happier this way, and so are we. The mother is able to keep an eye on the child and help with the feeding. On the other hand, it gives us an opportunity to explain to her a little bit about the rules of hygiene and balanced feeding. At night, the mother would climb into bed beside her little one and . . . And sure enough, here was the heart of the problem. The new cots were far too small for the mothers! We immediately brought out a supply of mats and bedding which could be spread on the floor beside the cots at night. Again word spread, and before long, things were pretty much back to normal.

Holy Family Hospital, Nangina

"Yes, the Pope is becoming a missionary, which means a witness, a shepherd, an apostle on the move. We are happy to repeat it now on this World Mission Day. Our journey, though very brief and simple, and limited to a single stopping place where solemn homage is paid to Christ present in the Eucharist, is intended to be a testimonial of gratitude for all missionaries of yesterday and of today who have consecrated their lives to the cause of the Gospel, for those especially who, following the footsteps of St. Francis Xavier, have "planted the Church," with so much self-sacrifice and success, in Asia and particularly in India.

"It is intended to be a symbol of solidarity with, and a stimulus and comfort to the whole missionary endeavor of the Holy Catholic Church.

"It is intended to be a first and prompt reply to the missionary appeal which the present ecumenical council makes to the same Church, to the end that every faithful member may foster within himself a solicitude for the spread of the Kingdom of Christ.

"It is intended to be an encouragement and approbation for all our missionaries scattered throughout the whole world, as well as for their sponsors and beneficiaries.

"It is intended to be a sign of love and esteem for all the peoples of the earth."

Pope Paul's announcement of his intended trip to The Bombay Eucharistic Congress October 18, 1964

The International African Institute will hold a seminar on the Impact of Christianity in Tropical Africa, from April 6th to April 16th at the University of Ghana. This will be the third in a second series of seminars devoted to research problems of significance for further social, economic and educational development in Africa. An important aim is to provide opportunities for research workers and other scholars holding posts in various parts of Africa to establish closer contact with each other and with their colleagues overseas, and to exchange views on problems and methods of research. The coming seminar will concentrate on the factors affecting the introduction and acceptance of Christianity in different

regions and its effects on values in the economic and political spheres and on social structure.

Papers and discussion will center on the following themes: "The introduction of Christianity into Africa in historical perspective;" "Missionary attitudes, methods, relationships and service;" "The interaction of Christianity and African life and thought;" and "Christianity in contemporary Africa."

AFRICAN STUDIES BULLETIN
May 1964

"If this is what the mission of the Church means, that the Church is to go into every context of life, into the political arena, into every social stratum, into every class of human society, into every occupation, into every language, into every culture and every portion of the globe, then all of us must be involved in this—those of us who are priests; those of us who will go into business endeavors to the far corners of the earth; those of us who will be engaged in activities which are more formally religious; and those of us who apparently spend most of our time in things that are not that patently Christian. We must go wherever human beings are; we must become one with them in everything which is not sin; we must bring the message of the gospel to them. Only if we bring Christ to them in this form of identification will they be able to accept us. Christianity is not the destruction of what is good. It is the transformation, the opening up, the amplifying of what is already there."

Rev. Bernard Cooke,
WORLD CAMPUS, Jan. 1965

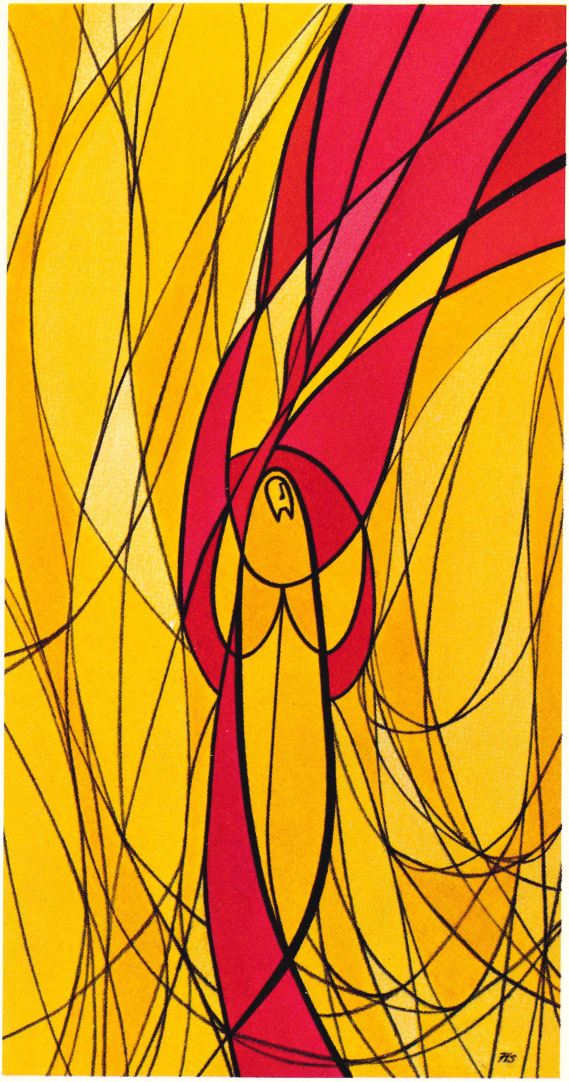
A national malaria eradication program begun in 1958 in India is showing results, according to a recent report that showed that no deaths were attributed to malaria in the country last year. The number of malaria attacks dropped to 50,000, compared to 1948 when malaria killed 2 million persons and afflicted 100 million others.

The AMA NEWS
November 9, 1964

BLESSED ARE THOSE WHO DIE IN THE LORD +

Please pray for our deceased benefactors:

Most Rev. W. R. Arnold, D.D., New York ✠ Right Rev. Msgr. Joseph J. Sondag, Atlantic, Iowa ✠ Sr. Mary Grace, R.S.M., Latrobe, Pa. ✠ Mr. Herman Auer, St. Louis ✠ Mr. Harry J. Brenner, Phila. ✠ Mrs. Kathleen Byrnes, Queens Village, N.Y. ✠ Mr. Joseph E. Consedine, St. Louis ✠ Mrs. Helen Fagan, Phila. ✠ Florence C. Koob, St. Louis ✠ Mr. R. W. McCarney, Phila. ✠ Mrs. Clara T. Meehan, Margate, N.J. ✠ Charles Mosolansky, Pittsburgh (Brother of Sr. M. Ambrose, S.C.M.M.) ✠ Mrs. Anne Nortner, San Francisco ✠ Mr. John L. Parisi, St. Louis ✠ Mrs. Ida Schulmeyer, Tampa, Fla. ✠ Mrs. Mary C. Smith, Hyattsville, Md. ✠ Mr. Lawrence F. Stadelman, St. Louis ✠ Mr. David Tarvin, New York ✠ Miss Nellie M. Walter, Wash., D.C.



THE ANNUNCIATION

The Holy Spirit splits the virgin heart
and opens her:
come, downtrodden of the earth.

The open heart
is missioner, martyr, mother from her birth.

Sister Miriam Therese S.C.M.M.

Holy Family Hospital, Patna, India, is in a jam. Our one and only anesthesia machine is about to collapse. Will you help us buy a new one?"

NAME_____

STREET_____

CITY_____ STATE_____

MEDICAL MISSION SISTERS
Philadelphia 11, Pa.